

Centers for Medicare & Medicaid Services, HHS

§419.30

(c) Partial hospitalization services furnished by community mental health centers (CMHCs).

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they are provided outside the patient's plan (of care); or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or by a hospice program furnishing services to patients outside the hospice benefit:

- (1) Antigens.
- (2) Splints and casts.
- (3) Hepatitis B vaccine.

(e) Effective January 1, 2005, an initial preventive physical examination, as defined in §410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

[65 FR 18542, Apr. 7, 2000, as amended at 67 FR 66813, Nov. 1, 2002; 69 FR 65863, Nov. 15, 2004]

§419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(a) Physician services that meet the requirements of §415.102(a) of this chapter for payment on a fee schedule basis.

(b) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(c) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(d) Certified nurse-midwife services, as defined in section 1861(gg) of the Act.

(e) Services of qualified psychologists, as defined in section 1861(ii) of the Act.

(f) Services of an anesthetist as defined in §410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Outpatient therapy services described in section 1833(a)(8) of the Act.

(i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if

applicable, the fee schedule established under section 1834(l).

(j) Except as provided in §419.22(b)(11), prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.

(k) Except as provided in §419.2(b)(10), durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Services for patients with ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(n) Services and procedures that the Secretary designates as requiring inpatient care.

(o) Hospital outpatient services furnished to SNF residents (as defined in §411.15(p) of this chapter) as part of the patient's resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital "under arrangements" but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

(p) Services that are not covered by Medicare by statute.

(q) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

(r) Services defined in §419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 69 FR 65863, Nov. 15, 2004]

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§419.30 Base expenditure target for calendar year 1999.

(a) CMS estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—